

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010447

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

372

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 25 1963

VS 300
Rev. 4/59

1 5117

2 8150

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4 0

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7 0

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9 204.3

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12 2-0

13 1-0

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Atchison</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Methodist Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Reside on Farm</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Asa</u> Last <u>Beers</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/1/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME <u>Joseph Beers</u>		11b. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u>	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		12b. SOCIAL SECURITY NO. <u>31</u>	
13. CAUSE OF DEATH (Enter only one cause per item. If more than one, list them in order of importance.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphatic leukemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		14. NAME OF HUSBAND OR WIFE <u>Mary Beers</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia left lower lobe</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>7</u> a.m. <u>11</u> p.m. Month <u>Feb.</u> Day <u>11</u> Year <u>1963</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>St. Joseph, Mo.</u>
21. I attended the deceased from <u>Feb. 11, 1963</u> to <u>March 17, 1963</u> and last saw him alive on <u>March 16, 1963</u> Death occurred at <u>7</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Sydney Z. Bryant M.D.</u>	
22b. ADDRESS <u>902 Edmund St., St. Joseph, Mo.</u>		22c. DATE SIGNED <u>3/19/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-19-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery, DeKalb County, Missouri</u>	23d. LOCATION (City, town, or county) (State) <u>Missouri</u>
24. FUNERAL DIRECTOR <u>Lyon Funeral Home, Inc., Plattsburg, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Mar. 20, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Hardell</u>			

SP1010-30

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RECEIVED DEPT. OF HEALTH

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81265

Permit issued 3-17-63

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed: Philip E. Cox

Licensed Embalmer No. 4993

P. O. Address Clairburg, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.